		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041707

Facility Name: Bement Health Care Center

Address: 601 North Morgan Street (Number) Bement (City) 61813 (Zip Code)

County: Piatt

Telephone Number: (217) 678-2191 **Fax #** (217) 678-7521

IDPA ID Number: 371346306001

Date of Initial License for Current Owners: 02/02/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,955	3,744	1,184	20,883	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,955	3,744	1,184	20,883	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.10%

D. How many bed-hold days during this year were paid by Public Aid?
244 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 02/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 02/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,184

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7 **	8	9	10	
1	Dietary	100,517	8,710	2,848	112,075		112,075		112,075			1
2	Food Purchase		89,924		89,924		89,924	(2,383)	87,541			2
3	Housekeeping	50,809	16,984		67,793		67,793	3	67,796			3
4	Laundry	33,012	11,076		44,088		44,088		44,088			4
5	Heat and Other Utilities			51,246	51,246		51,246	450	51,696			5
6	Maintenance	22,700	27,628	13,678	64,006		64,006	436	64,442			6
7	Other (specify):*											7
8	**TOTAL General Services**	207,038	154,322	67,772	429,132		429,132	(1,494)	427,638			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	504,076	33,801	1,200	539,077		539,077	9	539,086			10
10a	Therapy		341	76,644	76,985		76,985		76,985			10a
11	Activities	15,192	597	1,875	17,664		17,664		17,664			11
12	Social Services	19,775	168	1,225	21,168		21,168		21,168			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	539,043	34,907	91,744	665,694		665,694	9	665,703			16
	C. General Administration											
17	Administrative	127,236		(21,760)	105,476		105,476	21,760	127,236			17
18	Directors Fees											18
19	Professional Services			21,239	21,239		21,239	3,511	24,750			19
20	Dues, Fees, Subscriptions & Promotions			8,296	8,296		8,296	(353)	7,943			20
21	Clerical & General Office Expenses	29,883	5,691	11,230	46,804		46,804	6,342	53,146			21
22	Employee Benefits & Payroll Taxes			106,335	106,335		106,335	8,862	115,197			22
23	Inservice Training & Education			3,355	3,355		3,355	40	3,395			23
24	Travel and Seminar			3,320	3,320		3,320	1,146	4,466			24
25	Other Admin. Staff Transportation			2,735	2,735		2,735	1,518	4,253			25
26	Insurance-Prop.Liab.Malpractice			14,613	14,613		14,613	749	15,362			26
27	Other (specify):*											27
28	**TOTAL General Administration**	157,119	5,691	149,363	312,173		312,173	43,575	355,748			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	903,200	194,920	308,879	1,406,999		1,406,999	42,090	1,449,089			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Bement Health Care Center #0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			44,932	44,932		44,932	6,878	51,810			30
31	Amortization of Pre-Op. & Org.			2,036	2,036		2,036		2,036			31
32	Interest			124,832	124,832		124,832	88	124,920			32
33	Real Estate Taxes			29,874	29,874		29,874		29,874			33
34	Rent-Facility & Grounds							2,501	2,501			34
35	Rent-Equipment & Vehicles			5,039	5,039		5,039	3,056	8,095			35
36	Other (specify):*											36
37	**TOTAL Ownership**			206,713	206,713		206,713	12,523	219,236			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,845	1,263	18,108		18,108		18,108			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,940	32,940		32,940		32,940			42
43	Other (specify):* Nonallowable costs			2,407	2,407		2,407	(2,407)				43
44	**TOTAL Special Cost Centers**		16,845	36,610	53,455		53,455	(2,407)	51,048			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	903,200	211,765	552,202	1,667,167		1,667,167	52,206	1,719,373			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,497)	2		4
5	Telephone, TV & Radio in Resident Rooms	(850)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,156	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(234)	43		13
14	Non-Care Related Interest	(278)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(450)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(873)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule 5A	(1,464)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,490)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	55,696		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 55,696		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 52,206		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider # 0041707
12/31/2000

Schedule 5A

VI. Adjustment Detail
Non-Allowable Expenses
Line 29 - Other

Description	Amount	Schedule V Reference
Offset Miscellaneous Income	(86)	21
Offset Vending Income	(886)	2
Disallow PAC dues	(492)	20
Total	(1,464)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Bement Health Care Center

ID# 0041707

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
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70				70
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74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	60.00%	See Attached Schedule		See Attached Schedule		
Mark Petersen	40.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping		Petersen Health Care Companies	100.00%	$ 3	$ 3	1
2	V	5	Utilities		Petersen Health Care Companies	100.00%	450	450	2
3	V	6	Maintenance		Petersen Health Care Companies	100.00%	436	436	3
4	V	10	Nursing		Petersen Health Care Companies	100.00%	9	9	4
5	V	17	Administrative		Petersen Health Care Companies	100.00%	21,760	21,760	5
6	V	19	Professional Services		Petersen Health Care Companies	100.00%	3,511	3,511	6
7	V	20	Fees, Subscriptions & Dues		Petersen Health Care Companies	100.00%	139	139	7
8	V	21	Clerical & General Office Exp.		Petersen Health Care Companies	100.00%	6,428	6,428	8
9	V	22	Employee Benefits		Petersen Health Care Companies	100.00%	8,862	8,862	9
10	V	23	Inservice Training & Education		Petersen Health Care Companies	100.00%	40	40	10
11	V	24	Travel & Seminar		Petersen Health Care Companies	100.00%	1,146	1,146	11
12	V	25	Other Admin. Staff Transport.		Petersen Health Care Companies	100.00%	1,518	1,518	12
13	V	26	Insurance	$	Petersen Health Care Companies	100.00%	749	749	13
14	Total			$			$ 45,051	$ * 45,051	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation		Petersen Health Care Companies	100.00%	$ 4,722	$ 4,722	15
16	V	32	Interest		Petersen Health Care Companies	100.00%	366	366	16
17	V	34	Rent - Facility & Grounds		Petersen Health Care Companies	100.00%	2,501	2,501	17
18	V	35	Rent - Equipment & Vehicles		Petersen Health Care Companies	100.00%	3,056	3,056	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 10,645	$ * 10,645	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Petersen	President	Administrative	60.00%	534,934	5	12.5%	Salary	$ 66,898	L17, C1	1
2	Mark Petersen	Secretary	Administrative	40.00%	203,097	5	12.5%	Salary	25,399	L17, C1	2
3	Todd Petersen	Administrative	Administrative	0.00%	74,908	5	12.5%	Salary	9,368	L21, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 101,665		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, Illinois 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	187,869	8	$ 30	$	20,883	$ 3	1
2	5	Utilities	Patient Days	187,869	8	4,044		20,883	450	2
3	6	Maintenance	Patient Days	187,869	8	3,925		20,883	436	3
4	10	Nursing	Patient Days	187,869	8	82		20,883	9	4
5	19	Professional Service	Patient Days	187,869	8	31,588		20,883	3,511	5
6	20	Fees, Subscriptions & Dues	Patient Days	187,869	8	1,247		20,883	139	6
7	21	Clerical & General Office Exp.	Patient Days	187,869	8	57,826		20,883	6,428	7
8	22	Employee Benefits	Patient Days	187,869	8	79,721		20,883	8,862	8
9	23	Inservice Training & Education	Patient Days	187,869	8	358		20,883	40	9
10	24	Travel & Seminar	Patient Days	187,869	8	10,309		20,883	1,146	10
11	25	Other Admin. Staff Transport.	Patient Days	187,869	8	13,656		20,883	1,518	11
12	26	Insurance	Patient Days	187,869	8	6,741		20,883	749	12
13	30	Depreciation	Patient Days	187,869	8	42,481		20,883	4,722	13
14	32	Interest	Patient Days	187,869	8	3,291		20,883	366	14
15	34	Rent - Facility & Grounds	Patient Days	187,869	8	22,501		20,883	2,501	15
16	35	Rent - Equipment & Vehicles	Patient Days	187,869	8	27,493		20,883	3,056	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 305,293	$		$ 33,936	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Bank		x	Mortgage	$11,594.00	07/01/99	$ 1,165,000	$ 1,110,013	08/01/05	0.0850	$ 100,373	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Bank		x	Line of Credit	Interest Only	02/01/96	350,000	245,000	01/01/01	0.0875	17,945	6
7	Ackins Commercial Bank		x	Commission Note	$167.00	09/10/96	22,500	14,971	08/10/06	0.0900	3,598	7
8	First Bank		x	Car Loan	$899.75	07/16/00	32,395	26,996	01/16/03	0.0900	2,916	8
9	TOTAL Facility Related				$12,660.75		$ 1,569,895	$ 1,396,980			$ 124,832	9
	B. Non-Facility Related*											
10								Home Office Allocation			366	10
11								Interest Income Offset			(278)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 88	14
15	TOTALS (line 9+line14)						$ 1,569,895	$ 1,396,980			$ 124,920	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 28,054	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 28,964	2
3. Under or (over) accrual (line 2 minus line 1).		$ 910	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 28,964	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 29,874	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	18,339	8
	1996	27,385	9
	1997	27,192	10
	1998	28,054	11
	1999	28,964	12

Accrual is equal to 100% of the 1999 Real Estate Tax Bill of $ 28,964

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,000 B. General Construction Type: Exterior Block Frame Wood Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	109,829	1996	$ 33,600	1
2					2
3	TOTALS	109,829		$ 33,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1996		$ 780,146	$ 20,004	35	$ 22,290	$ 2,286	$ 109,593	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1996	3,650	252	20	183	(69)	841	9
10	Parking Lot			1996	1,669	116	20	83	(33)	354	10
11	Driveway			1996	1,050	73	20	53	(20)	239	11
12	Painting and Remodeling			1996	3,155	282	20	158	(124)	711	12
13	Curtains			1996	4,928	440	20	246	(194)	1,127	13
14	Walkway			1996	361	9	20	18	9	84	14
15	Alarm and Fire Equipment			1996	4,437	396	20	222	(174)	1,018	15
16	Sign			1996	434	39	20	22	(17)	124	16
17	Heating and Unit Platform			1996	1,219	109	20	61	(48)	356	17
18	300 Gallon Tank			1997	1,370	35	20	69	34	276	18
19	Install Gas Line			1997	1,861	48	20	93	45	357	19
20	Steel Door			1997	1,170	30	20	59	29	226	20
21	New Gas Line			1997	1,875	48	20	94	46	306	21
22	Gas Water Heater			1997	5,008	128	20	250	122	792	22
23	Zone Line Heaters			1997	730	87	20	37	(50)	133	23
24	Zone Line Heaters			1997	754	98	20	38	(60)	127	24
25	Generator Repair			1997	6,112		20	306	306	944	25
26	Ase Blacktop			1998	10,062	860	20	503	(357)	1,258	26
27	Electrical Service Generator Work			1998	1,846	47	20	92	45	230	27
28	Zone Line Heaters			1998	716	130	20	36	(94)	90	28
29	Heater			1999	4,956	1,214	20	248	(966)	372	29
30	Kickplates, Handrails			1999	1,803	46	20	90	44	135	30
31	Grade Driveway and Parking Lot			1999	3,100	294	20	155	(139)	233	31
32	Parking Lot Sealant			1999	1,060	101	20	53	(48)	80	32
33	Garage			2000	8,892	200	20	222	22	222	33
34	Door Frame Protectors			2000	1,059	15	20	26	11	26	34
35	Nine Windows			2000	2,290	17	20	57	40	57	35
36	TOTAL (lines 4 thru 35)				$ 855,713	$ 25,118		$ 25,764	$ 646	$ 120,311	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Zone Line Heater			2000	1,312	187	20	33	(154)	33	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,312	$ 187		$ 33	$ (154)	$ 33	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 122,366	$ 12,709	$ 12,239	$ (470)	10	$ 55,951	37
38	Current Year Purchases	4,936	705	247	(458)	10	247	38
39	Fully Depreciated Assets							39
40	Allocated from Management Co.			4,722	4,722			40
41	TOTALS	$ 127,302	$ 13,414	$ 17,208	$ 3,794		$ 56,198	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Use	2000 Oldsmobile Silhoutte	2000	$ 31,950	$ 3,060	$ 3,195	$ 135	5	$ 3,195	42
43	Facility Use	2000 Cadillac	2000	56,099	3,060	5,610	2,550	5	5,610	43
44										44
45										45
46	TOTALS			$ 88,049	$ 6,120	$ 8,805	$ 2,685		$ 8,805	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,105,976	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 44,839	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 51,810	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 6,971	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 185,347	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				2,501			6
7	TOTAL				$ 2,501 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 8,095 Description: Laundry Equipment $5,039 ; Allocated from Management Company $3,056
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	1,761	$	30,309	$	1,761	$ 30,309	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		163		5,765		163	5,765	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10a, C2-3	hrs		2,294		40,570	341	2,294	40,911	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39, C2	# of prescrpts					16,845		16,845	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Laboratory	L39, C3					951			951	13
	Radiology	L39, C3					312			312	
14	TOTAL			$	4,218	$	77,907	$ 17,186	4,218	$ 95,093	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center **#** 0041707 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,230	$ 4,230	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	263,121	263,121	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,223	30,223	6
7	Other Prepaid Expenses	1,524	1,524	7
8	Accounts Receivable (owners or related parties)	130,000	130,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 429,098	$ 429,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	33,600	33,600	13
14	Buildings, at Historical Cost	855,886	857,025	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	225,472	215,351	16
17	Accumulated Depreciation (book methods)	(217,411)	(185,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	170	170	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security Deposit	100,000	100,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 997,717	$ 1,020,799	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,426,815	$ 1,449,897	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 147,832	$ 147,832	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,368	34,368	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,964	28,964	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(125)	(125)	35
	Other Current Liabilities(specify):			
36	See schedule 17A	41,174	41,174	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 252,213	$ 252,213	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	286,967	286,967	39
40	Mortgage Payable	1,110,013	1,110,013	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,396,980	$ 1,396,980	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,649,193	$ 1,649,193	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (222,378)	$ (199,296)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,426,815	$ 1,449,897	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Bement Health Care Center
Provider # 0041707
12/31/2000

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Other Current Liabilities - Line 36

	Operating	After Consolidation
Wage Garnishment	466	466
Accrued Sales Tax	64	64
Accrued Interest	10,837	10,837
Accrued Insurance - General	27,386	27,386
Accrued Insurance - W/C	2,421	2,421
Total	41,174	41,174

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (105,616)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(1,676)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (107,292)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	310,031	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(425,117)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (115,086)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (222,378)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,735,062	1
2	Discounts and Allowances for all Levels	56,545	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,791,607	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	145,227	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 145,227	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,497	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	25,267	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,505	19
20	Radiology and X-Ray	468	20
21	Other Medical Services	1,520	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,257	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	278	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 278	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	4,829	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,829	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,977,198	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	429,132	31
32	Health Care	665,694	32
33	General Administration	312,173	33
	B. Capital Expense		
34	Ownership	206,713	34
	C. Ancillary Expense		
35	Special Cost Centers	20,515	35
36	Provider Participation Fee	32,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,667,167	40
41	**Income before Income Taxes (line 30 minus line 40)****	310,031	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 310,031	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Bement Health Care Center
Provider # 0041707
12/31/2000

Schedule 19A

XVII. INCOME STATEMENT
Revenue - Line 28

E. Other Revenue (specify):	Amount
Transportation	935
Vending	886
Miscellaneous	3,008
	4,829

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,429	2,515	$ 43,904	$ 17.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,847	4,878	76,599	15.70	3
4	Licensed Practical Nurses	6,287	6,442	80,143	12.44	4
5	Nurse Aides & Orderlies	33,240	33,544	287,778	8.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,013	2,020	15,192	7.52	9
10	Activity Assistants					10
11	Social Service Workers	1,993	2,080	19,775	9.51	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,167	23,114	10.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,513	12,048	77,403	6.42	15
16	Dishwashers					16
17	Maintenance Workers	2,109	2,151	22,700	10.55	17
18	Housekeepers	8,406	8,635	50,809	5.88	18
19	Laundry	5,178	5,249	33,012	6.29	19
20	Administrator	1,799	1,799	34,939	19.42	20
21	Assistant Administrator					21
22	Other Administrative	462	462	92,297	199.78	22
23	Office Manager					23
24	Clerical	1,661	1,755	24,116	13.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify) Transportation	576	648	5,767	8.90	32
33	Other(specify) Care Plan Coordinator	1,213	1,213	15,652	12.90	33
34	TOTAL (lines 1 - 33)	85,806	87,606	$ 903,200 *	$ 10.31	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	74	$ 2,848	L1, C3	35
36	Medical Director	Monthly	10,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,875	L11, C3	44
45	Social Service Consultant	44	1,225	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	158	$ 17,948		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		n/a		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill West	Administrator	0.00%	$ 3,417
Patti Wright	Administrator	0.00%	31,522
James Petersen	Administrative	60.00%	66,898
Mark Petersen	Administrative	40.00%	25,399
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,236

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ (21,760)
TOTAL (agree to Schedule V, line 17, col. 3)	$ (21,760)
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder	Legal	$ 683
Ginoli & Co.	Accounting	3,391
Altschuler, Melvoin & Glasser	Accounting	7,482
ADP	Computer Services	7,002
Mid America Programming	Computer Services	1,500
AHCA	Computer Services	805
Redline	Computer Services	226
America Online	Computer Services	150
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,239

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,218
Unemployment Compensation Insurance	13,910
FICA Taxes	58,561
Employee Health Insurance	14,021
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K	1,593
Employee Relations	2,369
Life Insurance	132
Physicals	531
Allocated from Management Company	8,862
TOTAL (agree to Schedule V, line 22, col.8)	$ 115,197

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
n/a		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	4,046
Health Care Worker Background Check	
(Indicate # of checks performed 30)	364
Illinois Health Care Association	2,544
Various Dues & Subscriptions	285
Various Licenses, Inspections & Permits	165
Allocated from Management Company	139
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,943

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	737
Seminar Expense	2,583
Allocated from Management Company	1,146
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,466

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3		N/A											
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $2,544**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,420** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **32,940**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **No** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,497**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **935**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **n/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.